



# NOTICE AND CERTIFICATE OF ACTION MEDICAL ASSISTANCE

State Form 1110 (R9 / 6-98) / FI 0619M

Approved by State Board of Accounts 1995

## NOTICE TO APPLICANT / RECIPIENT

See the back of this form for important information  
about your responsibilities and appeal rights.

|  |   |                        |
|--|---|------------------------|
| Name of applicant / recipient ( <i>last, first, middle</i> ) | County                                  |                        |
| Address ( <i>number and street, city, state, ZIP code</i> )  | Case number ( <i>case / cat / seq</i> ) |                        |
|  | Application date                        | Mailing date of Notice |

|   |                    |  |  |
|---|--------------------|--|--|
| <input type="checkbox"/> Your application for Medical Assistance was approved.  |                    | <input type="checkbox"/> Your Medicaid coverage is effective _____ |  |
| <input type="checkbox"/> Nursing Home Cases only: You are responsible for paying the following amount ( <i>liability</i> ) each month to the facility where you are residing:   |                    |  |  |
| \$ _____ effective  | \$ _____ effective | \$ _____ effective   |  |
| <input type="checkbox"/> Your eligibility for Medical Assistance was determined under the Spend-Down provision in accordance with 42 CFR 435.732.<br>Your Spend-Down amount is:   |                    |  |  |
| \$ _____ effective  | \$ _____ effective | \$ _____ effective   |  |
| <input type="checkbox"/> In order to receive Medicaid coverage each month, you must provide to the County Office of Family and Children proof of your incurred medical expenses ( <i>paid or unpaid</i> ), such as bills, receipts, and written statements from your medical providers. Your Medicaid coverage for the month will begin on the date that your medical expenses equal or exceed your spend-down amount and will continue through the last day of the month. ( <i>If you are a child under age 18 or a student age 18-21, your parents' medical expenses will count toward meeting your spend-down</i> )        |                    |  |  |
| <input type="checkbox"/> Your spend-down is the combined amount for yourself and your spouse. In order for you and your spouse to receive Medicaid coverage each month, you must provide to the County Office of Family and Children proof of your incurred medical expenses ( <i>paid or unpaid</i> ), such as bills, receipts, and written statements from your medical providers. Medicaid coverage for yourself and your spouse will begin on the date that your combined medical expenses ( <i>yours and your spouse's</i> ) equal or exceed your spend-down amount and will continue through the last day of the month. |                    |  |  |

|  |                       |
|--|-----------------------|
| <input type="checkbox"/> Your application for Medical Assistance was denied. | Reason(s) for denial: |
| Supporting law(s) or regulation(s):  |                       |

|   |   |   |
|---|---|---|
| <input type="checkbox"/> Effective _____ the following action is being taken by the County Office of Family and Children: |   |   |
| <input type="checkbox"/> Your Medical Assistance is being continued.  | <input type="checkbox"/> Your liability is \$ _____ | <input type="checkbox"/> Your Spend-Down amount is \$ _____             |
| <input type="checkbox"/> Your Medical Assistance is being suspended until _____.  |   | <input type="checkbox"/> Your Medical Assistance is being discontinued. |
| Reason(s) for the action:   |   |   |
| Supporting law(s) or regulation(s) for the adverse action:  |   |   |

|                         |
|-------------------------|
| Additional information: |
|-------------------------|

|                              |                                   |
|------------------------------|-----------------------------------|
| Signature of County Director | Date of action by County Director |
|------------------------------|-----------------------------------|

## YOUR RESPONSIBILITIES AND APPEAL RIGHTS AS A RECIPIENT OF MEDICAL ASSISTANCE

### 1. YOUR RESPONSIBILITIES

You must report to the County Office of Family and Children any change in your circumstances which may affect your eligibility for Medical Assistance ***within 10 days of the date the change occurs***. Changes which must be reported include, but are not limited to, the following:

- You or your spouse (*parent, if you are a child*) receive any money from a job, Social Security, inheritance, or any other source.
- Your income or that of your spouse (*parent, if you are a child*) increases, decreases, or stops.
- You move to another address, or to another County or State.
- You obtain real estate or other assets which you did not own at the time of application, or you plan to sell real estate.

If you are not sure about the types of changes that are to be reported to the County Office of Family and Children, you should contact your caseworker. You must keep in mind that a person who receives Medicaid by making false statements, by misrepresenting his situation, or by failing to report information will be required to make a repayment and may be criminally prosecuted under Indiana law.

2. **IMPORTANT:** If this notice states that your benefits will be discontinued, you may be eligible for Medicaid benefits under another category. If you have more information about your case, contact your caseworker within ten (10) days (*13 days if this notice is received by mail*) of the date of this notice.

The categories of the Medicaid program are listed below. In addition to meeting the categorical requirement, an individual must also meet specific income and resource requirements which vary according to the category.

#### NEWBORNS

TANF-RELATED - TANF Recipients

Persons ineligible for TANF due to dependent child income

Persons ineligible for TANF due to deemed income

#### TRANSITIONAL MEDICAL ASSISTANCE (TMA)

SSI RECIPIENTS ELIGIBLE FOR TANF EXCEPT FOR RECEIPT OF SSI

CHILDREN AGE 18, 19 AND 20 ELIGIBLE FOR TANF EXCEPT FOR THE 18 YEAR AGE LIMIT

CHILDREN UNDER AGE 21 RESIDING IN PSYCHIATRIC FACILITIES ELIGIBLE FOR TANF IF THEY WERE

LIVING AT HOME

PREGNANT WOMEN

CHILDREN UNDER AGE ONE

CHILDREN AGED ONE THROUGH FIVE

CHILDREN AGE SIX THROUGH EIGHTEEN

RBA-RELATED (INDIVIDUALS ELIGIBLE FOR ROOM AND BOARD ASSISTANCE)

INDIVIDUALS AGE 65 AND OLDER

BLIND INDIVIDUALS

DISABLED INDIVIDUALS

WARDS OF THE COUNTY OFFICE OF FAMILY AND CHILDREN

REFUGEES

QUALIFIED DISABLED WORKERS

QUALIFIED MEDICARE BENEFICIARIES

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES

3. YOUR RIGHT TO APPEAL AND HAVE A FAIR HEARING BEFORE A REPRESENTATIVE OF THE INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

If your application is denied you may file an appeal within ***30 days of the date of the notice of denial (33 days if the notice is mailed to you)***. As a recipient, if you disagree with any action taken on your Medical Assistance case, you may appeal within ***30 days of the effective date of the action. (33 days if the notice is mailed to you.)*** However, ***your benefits will not continue unless you appeal prior to the effective date of action.*** If you appeal and your benefits are continued, you will be required to repay assistance paid in your behalf pending the release of the hearing decision if the decision is that the action explained on the front side of this notice was correct.

### 4. HOW TO APPEAL

If you wish to appeal, send a letter with your signature to the County Office of Family and Children or to the Family and Social Services Administration, Hearings and Appeals Section, 402 W. Washington St., Room W392, Indianapolis, IN 46204 stating that you wish to appeal. Be sure the letter contains your address and a telephone number where you can be reached. If you have any questions or need help in requesting an appeal contact your caseworker. You will be notified in writing by the Indiana Family and Social Services Administration of the date, time and place for the hearing. You may represent yourself at the hearing or authorize a representative, such as an attorney, a relative, or a friend to do so.